STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State of VIRGINIA

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES FOR LONG-TERM CARE

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12 VAC 30-90-10

The policy and the method to be used in establishing payment rates for nursing facilities listed in §1905(a) of the Social Security Act and included in this State Plan for Medical Assistance are described in the following paragraphs.

a. Reimbursement and payment criteria will be established which are designed to enlist participation of a sufficient number of providers of services in the Program so that eligible persons can receive the medical care and services included in the Plan to the extent these are available to the general population.

b. Participation in the Program will be limited to providers of services who accept, as payment in full, the amounts so paid.

c. Payment for care of service will not exceed the amounts indicated to be reimbursed in accord with the policy and the methods described in the Plan and payments will not be made in excess of the upper limits described in 42 CFR 447.253(b)(2). The state agency has continuing access to data identifying the maximum charges allowed. Such data will be made available to the Secretary, HHS, upon request.

d. Payments for services to nursing facilities shall be on the basis of reasonable cost in accordance with the standards and principles set forth in 42 CFR 447.252 as follows:

   (1) A uniform annual cost report which itemizes allowable cost will be required to be filed within 150 days of each provider's fiscal year end.

   (2) The determination of allowable costs will be in accordance with Medicare principles as established in the Provider Reimbursement Manual (PRM-15) except where otherwise noted in this Plan.

   (3) Field audits will be conducted on the cost data submitted by the provider to verify the accuracy and reasonableness of such data. Audits will be conducted for each facility on a periodic basis as determined from internal desk audits and more often as required. Audit procedures are in conformance with SSA standards set forth in PRM-13-2. Internal desk audits are conducted annually within six months of receipt of a completed cost report from the provider.

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(4) Reports of field audits are retained by the state agency for at least three years following submission of the report.

(5) Facilities are paid on a cost-related basis in accordance with the methodology described in the Plan.

(6) Modifications to the Plan for reimbursement will be submitted as Plan amendments.

(7) Covered cost will include such items as:

(a) Cost of meeting certification standards.

(b) Routine services which include items expense providers normally incur in the provision of services.

(c) The cost of such services provided by related organizations except as modified in the payment system supplement 4.19-D.

(8) Bad debts, charity and courtesy allowances shall be excluded from allowable cost.

(9) Effective for facility cost reporting periods beginning on or after October 1, 1978, the reimbursable amount will be determined prospectively on a facility by facility basis, except that mental institutions and mental retardation facilities shall continue to be reimbursed retrospectively. The prospective rate will be based on the prior period's actual cost (as determined by an annual cost report and verified by audit as set forth in Section d. (3) above) plus an inflation factor. Payments will be made to facilities no less than monthly.

(10) The payment level calculated by the prospective rate will be adequate to reimburse in full such actual allowable costs that an economically and efficiently operated facility must incur. In addition, an incentive plan will be established as described in the payment system supplement 4.19-D.

(11) Upper limits for payment within the prospective payment system shall be as follow:

(a) Allowable cost shall be determined in accordance with Medicare principles as defined in PRM-15, except as may be modified in this plan.

(b) Reimbursement for operating costs will be limited to regional ceilings.

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(c) Reimbursement, in no instance, will exceed the charges for private patients receiving the same services. In accordance with §1903(a)(2)(B) of the Social Security Act, nursing facility costs incurred in relation to training and competency evaluation of nurse aides will be considered as State administrative expenses and, as such, shall be exempted from this provision.

(12) In accordance with 42 CFR 447.205, an opportunity for public comment was permitted before final implementation of rate setting processes.

(13) A detailed description of the prospective reimbursement formula is attached for supporting detail.

(14) Item 398D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

e. Reimbursement of non-enrolled long term care facilities.

(1) Non-enrolled providers of institutional long term care services shall be reimbursed based upon the average per diem cost, updated annually, reimbursed to enrolled nursing facility providers.

(2) Prior approval must be received from the DMAS for recipients to receive institutional services from non-enrolled long-term care facilities. Prior approval can only be granted:

(a) when the non-enrolled long term care facility with an available bed is closer to the recipient's Virginia residence than the closes facility located in Virginia with an available bed, or

(b) when long term care special services, such as intensive rehabilitation services, are not available in Virginia, or

(c) if there are no available beds in Virginia facilities.

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f. Specialized Care Services. The payment methodology for specialized care services is contained in Part XVII of the Nursing Home Payment System (12 VAC 30-90-264 et seq.).

12 VAC 30-90-11. Public comment process.

g. The State has in place a public process which complies with the requirements of §1902(a)(13)((A) of the *Social Security Act*.

12 VAC 30-90-266. Traumatic Brain Injury (TBI) Payment.

h. DMAS shall provide a fixed per day payment for nursing facility residents with TBI served in the program in accordance with resident and provider criteria, in addition to the reimbursement otherwise payable under the provisions of the Nursing Home Payment System (NHPS). Effective for dates of service on and after August 19, 1998, a per day rate add-on shall be paid for recipients who meet the eligibility criteria for these TBI payments and who are residents in a designated nursing facility TBI unit of 20 beds or more that meets the provider eligibility criteria. The value of the rate add-on shall be $22.00 on August 19, 1998. The rate add-on for any qualifying provider's fiscal year shall be reviewed annually to determine the appropriateness of the amount and any changes will be published and distributed to the providers . (Refer to 12 VAC 30-90-330 (Appendix VII) for related provider and recipient requirements.)